CHILDREN'S
DENTAL WORLD
smiles in any language

CONSENT FOR SOMEONE OTHER THAN PARENT/LEGAL GUARDIAN TO MAKE DENTAL HEALTH DECISIONS FOR MY CHILD AUTHORIZATION

I, _____ Authorize _____to bring my child/children to his/her appointments if I am unable to attend. I understand that medical/dental advice will be relayed to them on my behalf. I, _____ am the parent/legal guardian and preauthorize Children's Dental World and its personnel to deliver dental treatment and services to my child/children. Treatment may include, but is not limited to: dental examination, prophylaxis (cleaning), fluoride, x-rays, and any other treatment plan previously discussed and/or agreed upon by me, the parent/legal guardian or the authorized person listed below. During the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure or a different procedure than set forth in the treatment plan. I therefore authorize that such procedures as are necessary and desirable be performed in the exercise of the dentist's professional judgment. I understand and agree that the signatures and dates on this form will not expire without written notice and that a photocopy of this form is considered valid as the original. LIMITATIONS I do NOT authorize the following services/treatment. If "none", please state "NONE"_____. I accept financial responsibility for treatment completed on behalf of my child and agree to all of the above statements.

Please select one:

- I will call Children's Dental World at (312)-326-5437 to provide payment in advance of the appointment.
- The adult accompanying my child will provide payment at the time of service

Please provide a phone number that you can be reached during the appointment time for your child/children_____
(Phone Number)

Child/Children Name(s):

_____

Parent/Legal Guardian: Date:

Signature: _____ _____